APPENDIX I
Summary of Benefits & Coverage: Dental

Outline of Benefits

Plan Name: ***Northeast Delta Dental-Vermont Health Connect Dental Plan***

Benefits Period: Plan Year (January 1 – December 31)

NOTE: This Summary of Benefits & Coverage is only for the Adult portion (age 21+) of the *Northeast Delta Dental-Vermont Health Connect Dental Plan.*

Delta Dental PPO Benefits	Benefit Percentages Paid/Deductibles, etc.
Diagnostic & Preventive	**100%**
Basic Restorative (Deductible applies)	**70%**
Major Restorative (Deductible applies)	**50% (after a 6-month waiting period)**
Orthodontics	**N/A**
Plan Year Deductible	**$50 per Person**
Plan Year Maximum per Person	**$1,500**

Diagnostic & Preventive Benefits

Diagnostic:

- Limited oral evaluation.
- Oral evaluation – one time in any period of six (6) consecutive months. This can be a comprehensive or periodic evaluation provided by a specialist or a general dentist.
- Complete series or panoramic image once in any period of three (3) years; bitewing images once in any period of twelve (12) consecutive months; images of individual teeth as necessary.

Preventive:

- Prophylaxis (cleaning) – one time in any period of six (6) consecutive months. This can be a routine prophylaxis or a full mouth debridement under Diagnostic and Preventive, or periodontal maintenance under Basic Restorative.
- A full mouth debridement under Diagnostic and Preventive Benefits is covered once in any period of two (2) consecutive years and, when performed, is counted towards your prophylaxis benefit.

Exclusions & Limitations:

Certain covered services are subject to time and frequency limitations; time and frequency limitations are measured from the date the service was last performed. Covered services containing frequency limitations are available for more frequent treatment only with Prior Authorization. Certain covered

services apply to treatment for specified teeth. Certain procedures are considered a component or or part of a complete treatment, and not separately chargeable by the dentist. Fluoride treatments, sealants, space maintainers, cone beam imaging, and TMJ related services are not covered benefits. Other exclusions and limitations apply. Please refer to your policy for details.

Basic Restorative

Restorative:

- Amalgam (silver) restorations (fillings).
- Resin (white) restorations (fillings).

Periodontal:

- Treatment of diseased tissue supporting the teeth.
- Prophylaxis (cleaning) – one time in any period of six (6) consecutive months. This can be a routine prophylaxis or a full mouth debridement under Diagnostic and Preventive, or periodontal maintenance under Basic Restorative.
- A full mouth debridement under Diagnostic and Preventive Benefits is covered once in any period of two (2) consecutive years and, when performed, is counted towards your prophylaxis benefit.

Endodontics:

- Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy.

Oral Surgery:

- Extractions and covered surgical procedures.

Clinical Crown Lengthening:

- Once in a lifetime per tooth.

Palliative Treatment:

- Minor emergency treatment for the relief of pain.

Anesthesia:

- General anesthesia, intravenous sedation and non-intravenous conscious sedation are covered benefits when done in conjunction with other covered services.

Denture Repair:

- Repair of removable complete or partial denture to its original condition.

Exclusions & Limitations:

Certain covered services are subject to time and frequency limitations; time and frequency limitations are measured from the date the service was last performed. Covered services containing frequency limitations are available for more frequent treatment only with Prior Authorization. Certain covered services apply to treatment for specified teeth. Certain procedures are considered a component of or part of a complete treatment, and not separately chargeable by the dentist. Anesthesia may be administered only in conjunction with certain specified procedures. Tissue conditioning is not a covered benefit. Dentists may also be restricted from charging for certain repairs, replacements and retreatments. Certain procedures require dental consultant review or Prior Authorization, and Predeterminations are recommended for cases involving costly or extensive treatment plans. Other exclusions and limitations apply. Please refer to your Policy for details.

Major Restorative

Restorative Crowns:

- Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations.

Prosthodontics:

- Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures, including rebase and reline of such prosthetic appliances; core buildups; cast and prefabricated posts and cores; and fixed partial denture and crown repairs.

Implant Services:

- Surgical placement of an endosteal implant body including healing cap.

Implant Supported Prostheses:

- Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device.

Orthodontia:

- Orthodontic services are not a covered benefit under this plan.

Exclusions & Limitations:

Certain covered services are subject to time and frequency limitations; time and frequency limitations are measured from the date the service was last performed. Covered services containing frequency limitations are available for more frequent treatment only with Prior Authorization. Certain covered services apply to treatment for specified teeth. Certain procedures are considered a component of or part of a complete treatment, and are not separately chargeable by the dentist. Dentists may also be restricted from charging for certain repairs, replacements and retreatments. Certain procedures require dental

consultant review or Prior Authorization, and Predeterminations are recommended for case involving costly or extensive treatment plans. Other exclusions and limitations apply. Please refer to you Policy for details.

Orthodontic services are not a covered benefit under this plan.

APPENDIX I
Summary of Benefits & Coverage: Dental

Outline of Benefits

Plan Name: ***Northeast Delta Dental-Vermont Health Connect Dental with Pediatric High Option***

Benefits Period: Plan Year (January 1 – December 31)

NOTE: This Summary of Benefits & Coverage is only for the Pediatric portion (up to age 21) of the *Northeast Delta Dental-Vermont Health Connect Dental with Pediatric High Option*

Delta Dental PPO Benefits	**Enrollees Under Age 21**	
	Benefits prior to reaching the out-of-pocket maximum	Benefits after reaching the out-of-pocket maximum
Plan Year Out-of-Pocket Maximum[1]	$1,000	N/A
Diagnostic & Preventive	100%	100%
Basic Restorative (deductible applies)	70%	100%
Major Restorative (deductible applies)	50%	100%
Medically Necessary Orthodontia	50%	100%
Plan Year Deductible Per Person	$50	$0
Plan Year Maximum Per Person	None	None

[1]Only out-of-pocket expenses incurred by enrollees under the age of 21 for covered services received from Delta Dental PPO network Dentists are counted toward the plan year out-of-pocket maximum. Enrollees will keep the Under Age 21 benefits through the end of the plan year in which they turn 21.

Diagnostic & Preventive Benefits

Diagnostic:

- Limited oral evaluation.
- Oral evaluation – one time in any period of six (6) consecutive months. This can be a comprehensive or periodic evaluation provided by a specialist or a general dentist.
- Complete series or panoramic image once in any period of three (3) years; bitewing images once in any period of twelve (12) consecutive months; images of individual teeth as necessary.

Preventive:

- Prophylaxis (cleaning) – one time in any period of six (6) consecutive months (child prophylaxis through age thirteen (13), adult prophylaxis thereafter). This can be a routine prophylaxis or a full mouth debridement under Diagnostic and Preventive, or periodontal maintenance under Basic Restorative.

- A full mouth debridement under Diagnostic and Preventive Benefits is covered once in any period of two (2) consecutive years and, when performed, is counted towards your prophylaxis benefit.
- Fluoride treatment – one time in any period of six (6) consecutive months.
- Space Maintainers-one time in any period of two (2) consecutive years.
- Sealants-one time in any period of five (5) consecutive years on permanent 1st and 2nd molars.
- Preventive Restorations-one time per tooth in any period of five (5) consecutive years on permanent molars only.

Exclusions & Limitations:

Certain covered services are subject to time and frequency limitations; time and frequency limitations are measured from the date the service was performed. Covered services containing frequency limitations are available for more frequent treatment only with Prior Authorization. Certain covered services apply to treatment for specified teeth. Certain procedures are considered a component or part of complete treatment, and not separately chargeable by the dentist. Cone beam imaging, repair/replacement of space maintainers, and TMJ related services are not covered benefits. Other exclusions and limitations apply. Please refer to your Policy for details.

Basic Restorative

Restorative:

- Amalgam (silver) restorations (fillings).
- Resin (white) restorations (fillings).
- Prefabricated Stainless steel crowns

Periodontal:

- Treatment of diseased tissue supporting the teeth.
- Prophylaxis (cleaning) – one time in any period of six (6) consecutive months (child prophylaxis through age thirteen (13), adult prophylaxis thereafter). This can be a routine prophylaxis or a full mouth debridement under Diagnostic and Preventive, or periodontal maintenance under Basic Restorative.
- A full mouth debridement under Diagnostic and Preventive Benefits is covered once in any period of two (2) consecutive years and, when performed, is counted towards your prophylaxis benefit.

Endodontics:

- Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy.

Oral Surgery:

- Extractions and covered surgical procedures.

Clinical Crown Lengthening:

- Once in a lifetime per tooth.

Palliative Treatment:

- Minor emergency treatment for the relief of pain.

Anesthesia:

- General anesthesia, intravenous sedation, non-intravenous conscious sedation and nitrous oxide are covered benefits when done in conjunction with other covered services.

Denture Repair:

- Repair of removable complete or partial denture to its original condition.

Exclusions & Limitations:

Certain covered services are subject to time and frequency limitations; time and frequency limitations are measured from the date the service was performed. Covered services containing frequency limitations are available for more frequent treatment only with Prior Authorization. Certain covered services apply to treatment for specified teeth. Certain procedures are considered a component or part of complete treatment, and not separately chargeable by the dentist. Anesthesia may be administered only in conjunction with certain specified procedures. Dentists may also be restricted from charging for certain repairs, replacements and retreatment. Certain procedures require dental consultant review or Prior Authorization, and Predeterminations are recommended for cases involving costly or extensive treatment plans. Other exclusions and limitations apply. Please refer to your Policy for details.

Major Restorative

Restorative Crowns:

- Crowns when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations.

Prosthodontics:

- Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures, including rebase and reline of such prosthetic appliances; core buildups; cast and prefabricated posts and cores; and fixed partial denture and crown repairs.

Implant Services:

- Implant services are not covered under this plan. Implant supported prostheses services are not covered under this plan.

Orthodontics:

- Medically necessary treatment and procedures required for the correction of malposed (crooked) teeth, subject to Prior Authorization.
- Placement of device to facilitate eruption of an impacted tooth.

Exclusions & Limitations:

Certain covered services are subject to time and frequency limitations; time and frequency limitations are measured from the date the service was performed. Covered services containing frequency limitations are available for more frequent treatment only with Prior Authorization. Certain covered services apply to treatment for specified teeth. Certain procedures are considered a component or part of complete treatment, and not separately chargeable by the dentist. Dentists may also be restricted from charging for certain repairs, replacements and retreatment. Implant supported prostheses are not covered benefits. Certain procedures require dental consultant review or Prior Authorization, and Predeterminations are recommended for cases involving costly or extensive treatment plans. Other exclusions and limitations apply. Please refer to your Policy for details.

Medically necessary orthodontic treatment is subject to Prior Authorization and reimbursed for the length of the treatment, subject to continuing eligibility. Other exclusions and limitations apply. Please refer to your Policy for details.